STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155248	A. BUILDING _____ B. WING _____	03/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-BRENTWOOD	30 EAST CHANDLER AVE EVANSVILLE, IN47713

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F0000	This visit was for the Investigation of Complaint IN00087956. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00083702 completed on January 12, 2011. This visit was in conjunction with the PSR to the Investigation of Complaints IN00085197 and IN00085238 completed on February 2, 2011. Complaint IN00087956 - Substantiated. Federal/State deficiencies related to the allegations are cited at F246. Unrelated deficiencies are cited. Survey dates: March 23 and 24, 2011 Facility number: 000152 Provider number: 155248 AIM number: 100267510 Survey team: Anne Marie Crays RN Census bed type: SNF/NF: 82 Total: 82	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census payor type: Medicare: 9 Medicaid: 65 Other: 8 Total: 82 Sample: 11 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 3/29/11 by Suzanne Williams, RN			

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F0246 SS=D	Based on interview and record review, the facility failed to ensure call lights were answered in a timely manner, for 3 of 4 residents interviewed regarding call lights, in a sample of 11. Residents H, I, and K Findings include: 1. On 3/23/11 at 12:45 P.M., the Administrator provided a list of "Interviewable Residents." Residents H, I, and K were on this list. In a confidential interview with Resident H, Resident H indicated call lights were not always answered timely, and if they were, "sometimes the staff say they will be right back, and they don't come back." In a confidential interview with Resident I, Resident I indicated call lights were not answered timely, and it "was worse on 2nd shift." Resident I indicated that she had waited for as long as 1 hour. Resident I indicated, "The CNAs on 2nd shift seem to disappear." Resident I indicated when she needed assistance, she could not find staff. In a confidential interview with Resident K, Resident K indicated, "Call lights were a problem. 2nd shift more so." Resident K indicated call light response averaged "1/2	F0246	1) All interviewable residents were interviewed regarding alleged concerns of call lights being answered in a timely manner.2) All residents with the potential of being affected by the alleged concerns of call lights being answered in a timely manner were identified and interviewed.3) Education was given to staff regarding the matter of answering call lights in a timely manner. Additional observations will be made by evening managers two times weekly. Audits will be implemented two times weekly by SSD or designee to ensure call lights are being answered in a timely manner.4) Corrective actions will be moiitored by SSD or designee five times weekly and will be monitored by the ED in monthly in QAA meeting.Audits will be performed two times weekly for 3 months, and 1 time weekly for an additional 3 months, or longer if additional corrections are necessary.	04/08/2011

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	hour." 2. On 3/24/11 at 9:00 A.M., the Administrator provided Resident Council minutes for the previous 3 months. The minutes included: 1/18/11: "...Old Business: Call lights answered in a timely manner. Was the Issue Resolved to Your Satisfaction? No...New Business: Call lights are still not answered timely. Tired of hearing I will be right back. Number of residents who share the concern: 6 out of 7...." 2/15/11: "...Old Business: A. Call lights answered in a timely manner. Was the Issue Resolved to Your Satisfaction? 3 Yes, 8 No...New Business: A. Not enough help. Number of residents who share the concern: 10...C. Staff comes to see what residents need when lights on they shut off light [and] never come back. Number of residents who share the concern: 10...E. Upset because nurses won't help [with] what they need when their lights are on always say they will get a CNA. # of Residents Agree 10...." 3/16/11: "...Old Business: Staff comes in to see what the residents need when lights on they shut off light & never come back. Was the Issue Resolved to Your			

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	Satisfaction? No. Upset because nurses won't help [with] what they need when they turn the lights on they always say they will get a CNA. Was the Issue Resolved to Your Satisfaction? No. Not enough staff/help No...New Business...When light is on they answer call light but don't come back to solve problem...Number of residents who share the concern: 7 out of 9...." 3. In confidential interviews with staff members, 2 of 3 staff members indicated there was not enough staff on 2nd shift to care for the residents. Staff # 1 indicated, "There is not enough help. Sometimes residents are still eating dinner at 20 minutes till 8." Staff # 2 indicated, "There is not enough help [on 2nd shift]. It's been real bad lately." This federal tag relates to Complaint IN00087956. 3.1-3(v)(1)			

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F0279 SS=D	Based on interview and record review, the facility failed to ensure a plan of care was developed regarding fall prevention, for a resident assessed as being at risk for falls, for 1 of 1 resident reviewed for falls, in a sample of 11. Resident C. Findings include: 1. On 3/24/11 at 10:45 A.M., the Director of Nursing provided the current facility policy on "Falls Management," dated 4/24/06. The policy included: "The facility implements the falls prevention and intervention program including: During preadmission intake, determine if the potential resident has a history of falling or is unsteady in gait. Assure that the appropriate fall prevention equipment is available and in place prior to the resident's admission. Newly admitted/readmitted residents are assessed for fall risk by means of the Clinical Assessment. The Immediate Plan of Care at Risk for Falls is initiated. At risk residents are identified through a 'fall alert' communication system to care givers...The interdisciplinary team evaluates the fall prevention plan of care for residents 'at risk' for falls...." 2. The clinical record of Resident C was reviewed on 3/23/11 at 2:00 P.M. The	F0279	F279 1) Corrective action of alleged deficient practice was taken for resident "C", and a plan of care was initiated. All staff were educated and disciplinary action was given to immediate staff involved. 2) All other residents with the potential to be affected by the alleged deficient practice were identified and corrections were made as necessary. 3) All appropriate staff was educated in the area of the alleged deficient practice. Audits will be conducted daily on new admissions in clinical start-up to ensure a plan of care is put into place for fall prevention. 4) Corrective actions will be monitored by the DNS or designee in clinical start-up twice weekly for 3 months and 1 time weekly for an additional 3 months, or longer if additional corrections are needed. This will also be monitored by the ED in monthly QAA meetings.	04/08/2011

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resident was admitted to the facility on 2/25/11 with diagnoses including, but not limited to, closed fracture left hip. A hospital history and physical indicated the resident had fallen at home and fractured her hip.

An admission nursing note, the "Clinical Health Status," dated 2/25/11, indicated: "...Memory problem...Balance unsteady, NWB [non weight bearing], general debilitation...Risk for falls: Intermittent confusion, 1-2 falls in past 6 months, Chair bound...Legally blind, Balance problem while standing, Balance problem while walking, Lower extremity weakness...Total score of 10 or above deems resident at risk, Total Score 24...."

Nursing Progress Notes included the following notations:

2/27/11 at 7:24 P.M.: "Resident alert and some confusion noted this shift resident lying on side found in floor lying on right foot lasceration [sic] noted to rt [right] top of foot approx 4 inch lasceration[sic] noted...md called order received to asetnd [sic] to er for eval and tx [treat]."

A Hospital emergency room note, dated 2/27/11, indicated, "...The patient was evaluated shortly after arrival. She fallen

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	[sic] out of bed at the nursing home and sustained some contusions. Her main injury. [sic] Appeared to be a laceration to the dorsum of the right foot...The skin was very thin and fragile and was edematous and felt that sutures would not be usable at this time. Long quarter inch Steri-Strips were placed over the laceration and the skin edges were reapproximated. A dressing was applied and also placed a short leg OCL splint to decrease range of motion and risk of tearing the repair open...I did order a bed alarm to keep her from getting out of bed and injured [sic] herself again. Final Impression, Accidental fall with multiple contusions. 7 cm [centimeter] right dorsal foot laceration...." An "Immediate Plan of Care At Risk For Falls," dated 2/28/11, indicated: "Problem, At risk for falls related to: Fell in the past 30 days..." Interventions included: "...Call light available. Encourage rest periods daily to avoid overtiring...Evaluate need for bed alarm...." A plan of care regarding fall prevention prior to 2/28/11 was lacking in the clinical record. On 3/23/11 at 2:20 P.M., the Director of Nursing indicated the admitting nurse was			

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	responsible for initiating a plan of care on 2/25/11 regarding fall prevention. The DON indicated the Unit Manager should then follow up to ensure care plans were developed and interventions implemented. The DON indicated the admitting nurse had been reeducated on facility policy. 3.1-35(a)			

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F0323 SS=D	Based on interview and record review, the facility failed to develop a plan to prevent falls, including supervision and/or assistive devices, for a resident assessed as being at risk for falls, for 1 of 1 resident reviewed for falls, in a sample of 11. Resident C. Findings include: 1. On 3/24/11 at 10:45 A.M., the Director of Nursing provided the current facility policy on "Falls Management," dated 4/24/06. The policy included: "The facility implements the falls prevention and intervention program including: During preadmission intake, determine if the potential resident has a history of falling or is unsteady in gait. Assure that the appropriate fall prevention equipment is available and in place prior to the resident's admission. Newly admitted/readmitted residents are assessed for fall risk by means of the Clinical Assessment. The Immediate Plan of Care at Risk for Falls is initiated. At risk residents are identified through a 'fall alert' communication system to care givers...The interdisciplinary team evaluates the fall prevention plan of care for residents 'at risk' for falls...." 2. The clinical record of Resident C was	F0323	F323 1) Corrective actions were put into place for resident "C" for the alleged deficient practice. A plan of care was initiated to include a low bed, bed alarm, mat placed on floor and padding was installed on bed table. All staff were educated and disciplinary action was given to immediate staff involved. 2) All other residents with the potential to be affected by the alleged deficient practice were identified and corrections were made as necessary. 3) All appropriate staff was educated in the area of the alleged deficient practice. Education was given to appropriate staff in regards to supervision of residents and use of assistive devices for residents deemed as a fall risk Audits will be conducted daily on new admissions in clinical start-up to ensure a plan of care is put into place for those at risk for falls. 4) Corrective actions will be monitored by the DNS or designee in clinical start-up twice weekly for 3 months and 1 time weekly for 3 additional months, or longer if additional corrections are needed. This will also be monitored by the ED in monthly QAA meetings.	04/08/2011

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	reviewed on 3/23/11 at 2:00 P.M. The resident was admitted to the facility on 2/25/11 with diagnoses including, but not limited to, closed fracture left hip. A hospital history and physical indicated the resident had fallen at home and fractured her hip. An admission nursing note, the "Clinical Health Status," dated 2/25/11, indicated: "...Memory problem...Balance unsteady, NWB [non weight bearing], general debilitation...Risk for falls: Intermittent confusion, 1-2 falls in past 6 months, Chair bound...Legally blind, Balance problem while standing, Balance problem while walking, Lower extremity weakness...Total score of 10 or above deems resident at risk, Total Score 24...." Nursing Progress Notes included the following notations: 2/27/11 at 7:24 P.M.: "Resident alert and some confusion noted this shift resident lying on side found in floor lying on right foot lasceration [sic] noted to rt [right] top of foot approx 4 inch lasceration noted...md called order received to asetnd [sic] to er for eval and tx [treat]." A Hospital emergency room note, dated 2/27/11, indicated, "...The patient was			

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	evaluated shortly after arrival. She fallen [sic] out of bed at the nursing home and sustained some contusions. Her main injury. [sic] Appeared to be a laceration to the dorsum of the right foot...The skin was very thin and fragile and was edematous and felt that sutures would not be usable at this time. Long quarter inch Steri-Strips were placed over the laceration and the skin edges were reapproximated. A dressing was applied and also placed a short leg OCL splint to decrease range of motion and risk of tearing the repair open...I did order a bed alarm to keep her from getting out of bed and injured herself again. Final Impression, Accidental fall with multiple contusions. 7 cm [centimeter] right dorsal foot laceration...." An "Immediate Plan of Care At Risk For Falls," dated 2/28/11, indicated: "Problem At risk for falls related to: Fell in the past 30 days..." Interventions included: "...Call light available. Encourage rest periods daily to avoid overtiring...Evaluate need for bed alarm...." A plan of care regarding fall prevention prior to 2/28/11 was lacking in the clinical record. On 3/23/11 at 2:20 P.M., the Director of			

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	Nursing indicated the admitting nurse was responsible for initiating a plan of care on 2/25/11 regarding fall prevention. The DON indicated the Unit Manager should then follow up to ensure care plans were developed and interventions implemented. The DON indicated the admitting nurse had been reeducated on facility policy. 3.1-45(a)(2)			